

The government are very keen on amassing statistics. They collect them, add them, raise them to the nth power, take the cube root and prepare wonderful diagrams. But you must never forget that every one of these figures comes in the first instance from the village watchman, who just puts down what he damn pleases.

Anonymous English Judge

(Quoted by Sir Josiah Stamp in 'Some Economic Matters in Modern Life' (1929))

In this draft, we have attempted to do the following:

First, integrate the Guideline and the Guide and Codebook into one document. The combined document follows this introduction. Reformatting of the combined document is not complete. We would also want to incorporate many of the suggestions made during the latest comment period into the combined document. Questions about the guidelines marked with [red and brackets].

Second, address issues of data quality. The suggested approach to this issue starts from experience collecting data for a medical professional liability closed claim study, experience in different roles on numerous varied research projects, and experience with a large hospital professional liability insurer.

As the model act is currently written the entity that has to report the data can be an insuring entity, self-insurer, a health care provider (an individual or a large institution.) The actual individuals who are charged to provide the data will have equally varied backgrounds and experience with insurance, healthcare, research, and legal issues. It is very likely that the person providing the data will not be the person who negotiated a settlement or managed the claim.

There are several items in the model law that may be problematical because the existing definition of these items varies by entity, by individuals employed by entity, by state insurance departments, by researcher, and by users of the reports produced from the data. The existing definitions will be both explicit and implicit. The challenge from differing definitions can be addressed in part by providing definitions that are specific to the closed claim study. In other situations this won't work. If the entity doesn't have the information that is needed to provide the data according to the provided definition, there is a problem and data quality is reduced

Two of the situations where this may not work are

1. The provider who was primarily responsible for the medical malpractice incident has to be agreed to. This is implicit in item 5C. Reaching an agreement as to who the responsible party is can be subject to as much negotiation as a settlement with the plaintiff. There will be situations where arguably the incident is due to a systematic problem. I suspect this will only be a problem if the reporting entity is the health care provider who was primarily responsible.
2. 5K(2) of the model law claims that do not result in a verdict or judgment that itemizes damages (b) and (c) the insuring entity's or self-insurer best estimate of economic damages included in the settlement and their best estimate of noneconomic damages included in the settlement.

We wish to avoid the situation where the data provider "makes up" data to get the survey completed. Consequently we would structure the closed claim survey to allow

1. Asking for smaller items and allowing for "total items only if the details are not available. An alternative would be the inclusion of "other" or residual field.
2. Asking for additional explanatory items. For example, future economic damages could be discounted for the time value of money and the probability that a court case would be successful. There can be drastically different assumptions about what expenses will be incurred and when the expenses will be incurred. An open ended question that results in a brief explanation or set of choices may put the data provided into context and let the data analyst or researcher interpret the data in a meaningful way. For example, if the reporting entity has no better method than "half of

- the indemnity paid is economic and half is noneconomic” we would accept this if they explained that this was the method they were using.
3. We would not impose a methodology for coming up with a “best estimate” rather we would gather as much data as possible without adding distortion due to the survey instructions. This would provide users of the data with “reasonably clean” data that they could adjust (documenting their adjustments.) as suited their purposes.

Draft 9/10/08

New guideline on medical professional liability closed claim reporting

GUIDELINE FOR IMPLEMENTATION OF MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORTING

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Section 1. Statement of Purpose

This Guideline is intended to specify and promote uniform best practices for states implementing the *Medical Professional Liability Closed Claim Reporting Model Law, the model law*. The Guideline follows the layout of *the model law* with the addition of several appendices.

Section 2. Definitions and Codebook

The definitions can be found in the *Medical Professional Liability Closed Claim Reporting Model Law*. The following codebook enhances the definitions and provides guidance for making operational the definitions in *the model law*.

Codebook

Each claim represents each named individual or entity alleged to have contributed to an injury, and from whom compensation was sought. **All data elements for each claim pertain to the named individual or entity on whose behalf the claim is filed.** For example, the injury date should reflect the date that the individual or entity is alleged to have contributed to an injury, regardless of whether other parties are alleged to have also contributed to the injury at different times and places. Close dates should reflect the date on which a claim was closed for the individual or entity, regardless of whether other parties negotiate independent settlements at different times.

Table of Data Fields

Item #	Data Field	Description	Format
1	Ins_Code	Unique identifier assigned by the commissioner for each reporting entity.	Alphanumeric
2	Entity Name	Name of reporting entity	Alpha
3	ClaimID	Unique identifier for each claim	Numeric
4	IncID	Unique identifier for each incident	Numeric
5	PolLim_Occ_prim	Policy limits, primary coverage, per occurrence	Numeric
6	PolLim_Ann_prim	Annual policy limits, primary coverage	Numeric

Item #	Data Field	Description	Format
7	PolLim_Occ_Ex	Policy limits, all excess coverage, per occurrence (stacked if more than one applicable coverage-see below)	
8	PolLim_occ_ex	Annual policy limits, all excess coverage (stacked if more than one applicable coverage – see below).	
9	Lic_code	NPDB field of licensure code	Text, Left Zero Filled
10	Spec_code	NPDB medical specialty code	Text, Left Zero Filled
11	Facility	Code for type of facility where incident occurred	Text
12	Location	Code for the location within facility where incident occurred	Alphanumeric
13	Allegation_group	NPDB general allegation code	Text, Left Zero Filled
14	Allegation_code	NPDB specific allegation code	Text
15	City	City in which injury occurred	Text
16	County	County in which injury occurred	Text
17	County FIPS Code	3-digit county Federal Information Processing Standard Code	Text, Left Zero Filled
18	Zip Code	Five digit Zip code for place of injury.	Text, Left Zero Filled
19	Inj_gender	Gender of injured party (M, F)	Alpha – M or F
20	Inj_Age	Age of injured party	Numeric
21	Severity	Injury severity code. See Table X	Text
22	Inj_date	Earliest date of act or omission that was the proximate cause of the claim	MM/DD/YYYY
23	Rept_date	Date claim reported to insurer	MM/DD/YYYY
24	Suit_date	Date suit was filed, if applicable	MM/DD/YYYY
25	Close_date	Date claim was closed	MM/DD/YYYY
26	Disposition	Manner in which a claim is resolved	Alphanumeric
27	Disp_time		Text
28	Indemnity	Total indemnity paid by this entity	Numeric
29	Other_Indemnity	All other indemnity paid by all other parties	Numeric
30	Econ_ind	Economic indemnity paid by all parties	Numeric
31	Nonecon_ind	Non-economic indemnity paid by all parties	Numeric
32	Punitive damages	Punitive damages paid by all parties	Numeric
33	LAE_Defense	Loss adjustment expenses paid for legal costs	Numeric
34	LAE_Other	All other loss adjustment expenses paid	Numeric

Item Descriptions and Tables of Codes

Item 1: Entity ID Code

A unique identifier assigned by the commissioner for each reporting entity. Where applicable, a reporting entity's five-digit NAIC code may be used. [Will this work? What if a doctor is reporting because their RPG will not report? What number is used or assigned?]

Item 2: Entity Name

Full legal name of the insuring or reporting entity. [Information typed in by the reporting entity's representative can be problematic.]

Item 3: Claim ID

Each reporting entity should assign a unique identifier for each claim. This identifier should consist solely of numbers. Once a number has been used, it should not be repeated for any future claim. One claim record should be reported for each named individual or entity formally alleged to have contributed to an injury or grievance, and from whom a malpractice payment is being sought. Note that the claim identifier need not be the company's internal claim id. [Why not allow alphanumeric identifiers?]

Item 4: Incident Identifier

Each reporting entity should assign a unique numeric identifier for each occurrence. An occurrence is an event or series of events leading to an allegation of malpractice, and which may involve allegations against multiple individuals and entities. An occurrence is defined causally, and may or may not be constrained in time. For example, multiple failures to diagnose a given illness may occur over years. Such a series of events would be considered a single occurrence. [Why not allow alphanumeric identifiers?]

Item 5: Per occurrence policy limits, primary coverage

The maximum amount a primary insurer will pay for a single malpractice claim under the terms of the policy. [Whose policy?]

Item 6: Annual policy limits, primary coverage

The maximum amount a primary insurer will annually pay under the terms of a policy for one or more malpractice claims. The reported policy limit should reflect all policies in effect for a given claim (see above). [provide examples, how is self insurance handled? For a self insured there may not be an annual aggregate.]

Item 7: Per occurrence policy limits, all excess coverage combined

The combined maximum amount all excess insurers will pay for a single malpractice claim under the terms of the policy. Policy limits should reflect the cumulative limits of all policies other than the primary coverage in effect for a given claim. For example, if a policy was issued with a \$1 million limit, and an additional excess policy had a \$5 million limit, a total limit of \$6 million should be reported. [provide examples of how you want this to work.]

Item 8: Annual policy limits, all excess coverage combined

The combined maximum amount all excess insurers will annually pay under the terms of their respective policies or contracts. The reported policy limit should reflect all excess policies in effect for a given claim (see above).

Item 9: NPDB Occupation / Field of Licensure Code

Enter the field of licensure code from the following table for individuals named in a malpractice action. If an institution is named in the claim, enter 999.

NPDB Occupation/Field of Licensure Codes	
Code	Description
Chiropractor	
603	Chiropractor
Counselor	
621	Counselor-Mental Health
651	Professional counselor
654	Professional counselor-alcohol

657	Professional counselor-family/marriage
660	Professional counselor-substance abuse
661	Marriage and family therapist
Code	Description
Dental Service Provider	
030	Dentist
035	Dentist/Resident
606	Dental assistant
609	Dental hygienist
612	Denturist
Dietician/Nutritionist	
200	Dietician
210	Nutritionist
Emergency Med Tech (EMT)	
250	EMT, Basic
260	EMT, Cardiac, critical care
270	EMT, Intermediate
280	EMT, Paramedic
Eye and Vision Service Provider	
630	Ocularist
633	Optician
636	Optometrist
Nurse	
100	Registered
110	Nurse anesthetist
120	Nurse midwife
130	Nurse practitioner
140	Licensed practical
141	Clinical nurse specialist
Nurse aides, Home health aide, and other aide	
148	Certified nurse aide/assistant
150	Nurses aide
160	Home health aide
165	Health care aide/direct care worker
175	Certified or qualified medication aide
Pharmacy Service Provider	
050	Pharmacist
055	Pharmacy intern
060	Pharmacist, nuclear
070	Pharmacy assistant
075	Pharmacy technician
Physician	
010	Physician (MD)
015	Physician inter/resident (MD)
020	Osteopathic Physician (DO)
025	Osteopathic Physician Intern/Resident (DO)
Physician Assistant	
642	Physician assistant, allopathic
645	Physician assistant, osteopathic
Podiatric Service Provider	
350	Podiatrist

648	Podiatric assistant
Code	Description
Psychologist/Psychological Asst.	
371	Psychologist
372	School psychologist
373	Psychological assistant, associate, examiner
Rehabilitative, respiratory, and restorative service Provider	
402	Art/Recreation therapist
405	Massage therapist
410	Occupation therapist
420	Occupational therapy assistant
430	Physical therapist
440	Physical therapy assistant
450	Rehabilitation therapist
663	Respiratory therapist
666	Respiratory therapy technician
Social worker	
300	Social worker
Speech, language, and hearing service provider	
400	Audiologist
460	Speech/language pathologist
470	Hearing aid/hearing instrument specialist
Technologist	
500	Medical technologist
505	Cytotechnologist
510	Nuclear medicine technologist
520	Radiation therapy technologist
530	Radiologist technologist
Other Health Care Practitioner	
600	Acupuncturist
601	Athletic trainer
615	Homeopath
618	Medical assistant
624	Midwife, Lay (non-nurse)
627	Naturopath
639	Orthotics/ Prosthetics Fitter
170	Psychiatric Technician
699	Other health care practitioner-not classified
Health Care Facility Administrator	
752	Adult care facility administrator
755	Hospital administrator
758	Long-term care administrator
999	Not an individual defendant.

Item 10: NPDB Medical Specialty Codes

Select the most relevant specialty code from the following table.

NPDB Specialty Codes	
Code	Description
Physician Specialties	

01	Allergy and immunology
03	Aerospace medicine
05	Anesthesiology
Code	Description
13	Child Psychiatry
20	Dermatology
23	Diagnostic Radiology
25	Emergency medicine
29	Forensic pathology
30	Gastroenterology
33	General / Family Practice
35	General preventive medicine
37	Hospitalist
39	Internal medicine
40	Neurology
43	Neurology, clinical neurophysiology
45	Nuclear medicine
50	Obstetrics & Gynecology
53	Occupational medicine
55	Ophthalmology
59	Otolaryngology
60	Pediatrics
63	Psychiatry
65	Public health
67	Clinical pharmacology
69	Physical medicine & rehabilitation
70	Pulmonary diseases
73	Anatomic/clinical pathology
75	Radiology
76	Radiation oncology
80	Colon and rectal surgery
81	General surgery
82	Neurological surgery
83	Orthopedic surgery
84	Plastic surgery
85	Thoracic surgery
86	Urological surgery
98	Other specialty-not classified
99	Unspecified
Dental specialties	
D1	General dentistry (no specialty)
D2	Dental: Public Health
D3	Endodontics
D4	Oral and maxillofacial surgery
D5	Oral and maxillofacial pathology
D6	Orthodontics and dentofacial Orthopedics
D7	Pediatric Dentistry
D8	Periodontics
D9	Prosthodontics
DA	Oral and maxillofacial radiology
DB	Unknown

Item 11: Type of facility Code

Type of facility	
Code	Description
Group or Practice	
361	Chiropractic Group / Practice
362	Dental Group / Practice
363	Optician / Optometric Group / Practice
364	Podiatric Group / Practice
365	Medical Group / Practice
366	Mental health / Substance Abuse Group / Practice
393	Home health Agency / Organization
383	Hospice / Hospice Care Provider
Hospital	
301	General/Acute Care Hospital
302	Psychiatric hospital
303	Rehabilitation Hospital
304	Federal Hospital
Hospital Unit	
307	Psychiatric Unit
308	Rehabilitation Unit
310	Laboratory/CLIA Laboratory
389	Nursing Facility/Skilled Nursing Facility
370	Research Center/Facility
Other Health Care Facility	
381	Adult Day Care Facility
383	Intermediate Care Facility for Mentally Retarded/Substance Abuse
386	Residential Treatment Facility/Program
388	Outpatient Rehabilitation Center/Comprehensive Outpatient Rehabilitation Center
391	Ambulatory Surgical Center
392	Ambulatory Clinic/Center
394	Health Center/Federally Qualified Health Center/Community Health Center
395	Mental Health Center/Community Mental Health Center
396	Rural Health Clinic
397	Mammography Service Provider
398	End Stage Renal Disease Facility
399	Radiology/Imaging Center
Managed Care Organization	
331	Health Maintenance Organization
335	Preferred Provider Organization
336	Provider Sponsored Organization
338	Religious, Fraternal Benefit Society Plan
320	Health Insurance Company/Provider
Health Care Supplier/Manufacturer	
342	Blood Bank
343	Durable medical Equipment Supplier

344	Eyewear Equipment Supplier
345	Pharmacy
346	Pharmaceutical Manufacturer
347	Biological Products manufacturer
Code	Description
349	Portable X-Ray Supplier
351	Fiscal/Billing/Management Agency
352	Purchasing Service
353	Nursing/Health Care Staffing Service
390	Ambulance Service/Transportation Company
999	Other not specified

Item 12: Location within facility where incident occurred

Code	Description
Inpatient Facilities	
1	Catheterization lab
2	Critical care unit
3	Dispensary
4	Emergency department
5	Labor and delivery room
6	Laboratory
7	Nursery
8	Operating room
9	Outpatient department
10	Patient room
11	Pharmacy
12	Physical therapy department
13	Radiation therapy department
14	Radiology department
15	Recovery room
16	Rehabilitation center
17	Special procedure room
Location other than inpatient facility	
18a	Clinical support center, such as a laboratory or radiology center
18b	Office
18c	Walk-in clinic
18d	Other
Other and Unknown	
19	Other department in hospital
20	Unknown
21	Other

Item 13: Allegation Group

001 = Diagnosis related 060 = Treatment related
010 = Anesthesia related 070 = Monitoring related
020 = Surgery Related 080 = Equipment / Product Related
030 = Medication Related 090 = Other / Miscellaneous
040 = IV & Blood Products Related 100 = Behavioral Health
050 = Obstetrics related

Item 14: NPDB Allegation Code

Instructions

1. Select the code that is most descriptive of the alleged error or omission.

Example 1: Select “wrong dosage administered” (324) for dosage errors rather than the more generic “improper performance” (306).

Example 2: Select “delay in treatment of identified fetal distress” (203) if appropriate, rather than “delay in performance” (201).

More generic categories should be used only when a specific category that adequately describes the allegation does not exist.

2. This is taxonomy of *allegations* made by the claimants. If the claimant alleges that an infection is the result of a surgery, select the code *failure to use aseptic technique*, even if there is no specific known, proven, or identified performance failure.

3. Identify the most accurate code.

Example 1: Do not conflate codes such as a failure to treat fetal distress (104) with a failure to identify fetal distress (103) with delay in treatment of fetal distress (203). **Example 2:** Do not conflate a failure to order appropriate medication (107) with instances in which the wrong medication is ordered (329).

3. Select the most causally relevant code. If numerous errors are alleged to have contributed to an injury, identify the first error that was necessary to occur to have produced the sequence of actions ultimately leading to an adverse outcome. For example, if an illness is misdiagnosed, and the misdiagnosis leads to the prescription of improper medication, the “cause” of the injury is the initial misdiagnosis. The initial action is the first “necessary” but not necessarily “sufficient” condition that ultimately led to harm. In the absence of this initial event (misdiagnosis), the most proximate cause of harm (improper prescription) would not have occurred.

NPDB Allegation Codes	
Failure to Take Appropriate Action	
100	Failure to use aseptic technique
101	Failure to diagnose
Excludes misdiagnoses (323), and delay in diagnosis (200). Use code only to indicate instances of a conclusion that no condition worthy of follow-up or treatment existed, when it in fact did exist.	
102	Failure to delay case when indicated
103	Failure to identify fetal distress
104	Failure to treat fetal distress
105	Failure to medicate

- 106 Failure to monitor
- 107 Failure to order appropriate medication
- 108 Failure to order appropriate test
- 109 Failure to perform preoperative evaluation
- 110 Failure to perform procedure
- 111 Failure to perform resuscitation
- 112 Failure to recognize a complication
- 113 Failure to treat

Delay in Performance

- 200 Delay in diagnosis
- 201 Delay in performance
- 202 Delay in treatment
- 203 Delay in treatment of identified fetal distress

Error / Improper Performance

- 300 Administration of blood or fluid problems
- 301 Agent use or selection error
- 302 Complimentary or alternative medication problem
- 303 Equipment utilization problem
- 304 Improper choice of delivery method
- 305 Improper management
- 306 Improper performance
- 307 Improperly performed C-Section
- 308 Improperly performed vaginal delivery
- 309 Improperly performed resuscitation
- 310 Improperly performed test
- 311 Improper technique
- 312 Intubation problem
- 313 Lab error
- 314 Pathology error
- 315 Medication administered via the wrong route
- 316 Patient history
- 317 Problems with patient monitoring in recovery
- 318 Patient monitoring problem
- 319 Patient position problem
- 320 Problem with appliance
- 321 Radiology or imaging error
- 322 Surgical or other foreign body retained
- 323 Wrong diagnosis or misdiagnosis
- 324 Wrong dosage administered
- 325 Wrong dosage dispensed
- 326 Wrong dosage ordered of correct medication
- 327 Wrong medication administered
- 328 Wrong medication dispensed
- 329 Wrong medication ordered
- 330 Wrong body part
- 331 Wrong blood type
- 332 Wrong equipment
- 333 Wrong patient
 - 334 Wrong procedure or treatment

Unnecessary/Contraindicated Procedure

- 400 Contraindicated procedure
- 401 Surgical or procedural clearance contraindicated
- 402 Unnecessary procedure
- 403 Unnecessary test
- 404 Unnecessary treatment

Communication/Supervision

- 500 Communication problem between practitioners
- 501 Failure to instruct or communicate with patient of family
- 502 Failure to report on patient condition
- 503 Failure to respond to patient
- 504 Failure to supervise
- 505 Improper supervision

Continuity of Care / Management

- 600 Failure/delay in admission to hospital
- 601 Failure/delay in referral or consultation
- 602 Premature discharge from institution
- 603 Altered, misplace, or prematurely destroyed records

Behavioral / Legal

- 700 Abandonment
- 701 Assault and Battery
- 702 Breach of contract or warranty
- 703 Breach of patient confidentiality
- 704 Equipment malfunction
- 705 Breach of regulation
- 706 Failure to ensure patient safety
- 707 Failure to obtain consent / lack of informed consent
- 708 Failure to protect 3rd party
- 709 Failure to test equipment
- 710 False imprisonment
- 711 (Legal, ethical, or moral) improper conduct
- 712 Inadequate utilization review
- 713 Negligent credentialing
- 714 Practitioner with communicable disease
- 715 Product liability
- 716 Religious issues
- 717 Sexual misconduct
- 718 Third party claimant
- 719 Vicarious liability
- 720 Wrong life/birth
- 899 Cannot be determined from available records.
- 999 Allegation not otherwise classified

Item 15: City where injury occurred

Full name of the city in which the alleged injury occurred. The city should correspond to the alleged error or omission identified on item 14. [Having the reporting entity's representative type this in will lead to inconsistencies.]

Item 16: County where injury occurred

Full name of the county in which the injury is alleged to have occurred. The county should correspond to the alleged error or omission identified on item 14. [Having the reporting entity's representative type this in will lead to inconsistencies.]

Item 17: County FIPS Code

Three digit Federal Information Processing Standard Code (FIPS) for the county in which the injury occurred. Do not omit leading zeros (001, 023, etc).

Item 18: Five digit **Zip Code** of the location where injury occurred.

[We have asked for location information in 4 different items. What if you get 4 inconsistent responses?]

Item 19: Gender of injured person. Use M or F.

Item 20: Age of injured person. [At what point in time? Do you want their age when injured, when suit is filed or what? If you want their age at the time of injury, we may want to allow ranges birth, minor, adult, or senior.]

Item 21: Severity of injury code**Code Severity Description Examples****Temporary Injuries (Codes 1-4)**

- 1 Emotional injury Fright, no physical injury
- 2 Insignificant Lacerations, contusions, minor scars or rash, no delay in recovery
- 3 Minor Infection, fracture set improperly, fall in hospital. Recovery is delayed but complete

4 Major Burns, surgical material left, drug side effect or brain injury. Recover is delayed but complete

Permanent Injuries

5 Minor Loss of fingers, loss or damage to minor organs. Injury is not disabling

6 Significant Deafness, loss of limb, loss of eye, loss of one kidney or lung

7 Major Paraplegia, blindness, loss of two limbs, or brain damage

8 Grave Quadriplegia, severe brain damage, life-long care or fatal prognosis

9 Death

Item 22: Date of injury

Report the date of the earliest alleged error or omission that was the first necessary if not sufficient cause of the alleged medical injury. This date should correspond to the error or omission code identified on item 14.

Item 23: Date claim was reported

The date that an insurer received a formal demand for payment for injuries arising out of alleged medical negligence. If

no insurance coverage is available, use the date that the medical provider or facility received such notice.

Item 24: Date of lawsuit

The date a lawsuit was filed for this claim.

Item 25: Date claim was closed.

Item 26: Claim Disposition Code

Claim Disposition Codes	
Code	Description
1	Claim is abandoned by the claimant.
2	Claim is settled by the parties.

Claims disposed of by a court

3a Directed verdict for the plaintiff

3b Directed verdict for the defendant

3c Judgment notwithstanding verdict for the plaintiff (judgment for the defendant)

3d Judgment notwithstanding verdict for the defendant (judgment for the plaintiff)

3e Involuntary dismissal

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3f Judgment for the plaintiff

3f Judgment for the defendant

3f Judgment for the plaintiff after appeal

3f Judgment for the defendant after appeal

Claims settled by an alternative dispute resolution process

4a Arbitration

4b Mediation

4c Private judging or private trial

4d Other type of alternative dispute resolution process

[I am not sure that the person who is filling out the form for the entity will be able to make these distinctions. Do we need this level of detail?]

Item 27: Timing of Disposition Code

Timing of Disposition	
Code	Description
1	Before filing suit or requesting arbitration or a mediation hearing
2	Before trial, arbitration or mediation

- 3 During trial, arbitration or mediation
 - 4 After trial or hearing, but before judgment or award
 - 5 After judgment or decision, but before appeal
 - 6 During an appeal
 - 7 After an appeal; or
 - 8 During review panel or non-binding arbitration.
- [I am not sure that the person who is filling out the form for the entity will be able to make these distinctions. Do we need this level of detail?]

Item 28: Indemnity paid by reporting entity

The amount of indemnity paid by the insurer reporting the claim, exclusive of any other amounts paid by any other insurer or party.

[If a doctor is filling this out because their RPG refuses to do so, do they report what they paid out of pocket or what the RPG paid? What if a self insurer if filling out the report?]

Item 29: All other indemnity paid

The total amount paid by all other insurers or parties for this claim.

Note on items 30 and 31: Economic and noneconomic portions of total indemnity paid by all parties.

Amounts entered into items 28 and 29 should reasonably reflect available documentation obtained during the course of

adjudicating a claim regarding actual economic costs incurred by the injured party due to the alleged medical negligence.

Economic damages should reflect the reporting entity’s best estimate of current and future lost wages, current and future

medical costs, and any other pecuniary costs arising from the alleged act of malpractice. Arbitrarily apportioning economic

and non-economic damages 50%-50% or via some other heuristic rule is not acceptable.

For costs that are not documented, each reporting entity should develop a reasonable methodology for imputing values.

For example, lost life-time wages of a minor who lacks any employment history may be estimated via generally accepted

econometric or actuarial methods that would be accepted in a court of law.

Noneconomic damages should not exceed any tort limitations such as damage caps that exist in the relevant jurisdiction.

Within such constraints, noneconomic damages should bear a reasonable relationship to the nature and severity of the injury

in terms of limitations on major life activities formerly enjoyed by the injured party, physical pain and suffering, loss of

consortium, psychological or mental consequences of the injury, and any other reasonable non-pecuniary losses.

Reporting entities should be prepared to document and justify allocation methodologies upon request of the insurance

commissioner. **If the sum of estimated economic and non-economic damages exceed total indemnity, the amount**

allocated to non-economic damages should be reduced by a proportionate amount.

Item 30: Economic Indemnity. Portion of total indemnity designed to compensation an injured party for pecuniary losses,

such as lost wages and medical costs attributable to the iatrogenic injury.

Item 31: Non-economic indemnity. Portion of the total indemnity designed to compensate an injured party for other than

pecuniary losses, such as pain and suffering, diminished quality of life, or loss of consortium.

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Item 32: Punitive damages. Amounts awarded for purposes other than compensation, such as awards designed to punish or deter grossly negligent conduct.

Item 33: Loss Adjustment Expense (LAE) paid for legal defense. Include amounts paid to legal staff, expert witnesses, court costs, and any other amounts directly related to legal costs associated with this claim.

Item 34: Loss Adjustment Expense (LAE) for other than legal defense. All other costs incurred during the course of adjudicating this claim, but excluding legal costs.

Section 3. Applicability and Scope

This Guideline is intended to apply to any state that enacts the *Medical Professional Liability Closed Claim Reporting Model Law* or has similar data reporting requirements.

Section 4. Claims Required to Be Reported

A. The types of closed medical professional liability claims that must be reported to the commissioner include:

- (1) Claims closed with an indemnity payment;
- (2) Claims closed with paid defense and cost containment expenses; and
- (3) Claims closed with both indemnity payments and paid defense and cost containment expenses.

B. If a self-insurer, facility or provider waives copayments, forgives bills or deductibles, or makes other similar accommodations to a client, it is not a claim under subsection 2A of the *Medical Professional Liability Closed Claim Reporting Model Law*. Reporting entities are not required to report these types of accommodations to the commissioner.

C. A claim is closed on the date the reporting entity takes final administrative action to close the claim. Final administrative action occurs after the reporting entity:

- (1) Issues the final payment to the claimant in the form of a check or draft;
- (2) Pays all outstanding bills for defense and cost containment expenses; and
- (3) If applicable, receives all indemnity and defense and cost containment expense payment data needed for reporting from a facility, provider or excess insuring entity.

D. If a closed claim is reopened to update data, the reporting entity must report the updated data to the commissioner after it updates and closes the claim file.

Section 5. Assignment of Claim and Incident Identifiers

A. The reporting entity must assign a different claim identifier to each closed claim report.

(1) The claim identifier must consist solely of numbers. The commissioner will combine the reporting entity's user ID with the claim identifier to create a unique record identifier for each claim.

(2) The commissioner may use the record identifier to trace the claim for auditing purposes.

B. If a claimant makes claims against more than one facility or provider insured by an insuring entity or self-insurer, the insuring entity or self-insurer must report each claim separately and include an incident identifier.

(1) The incident identifier must consist solely of numbers.

(2) The insuring entity or self-insurer is responsible to report claims only if it provides insurance coverage for a facility or provider and defends the claim.

Section 6. Responsibility for Reporting Data

A. Primary insuring entities are principally responsible for reporting closed claim data required under the *Medical Professional Liability Closed Claim Reporting Model Law*.

(1) The primary insuring entity must report the total amounts paid to settle the claim, including any indemnity or defense and cost containment expense payments made by:

- (a) A facility or provider;
- (b) An excess insuring entity; or
- (c) Any other person or entity on behalf of the facility or provider.

(2) Facilities or providers insured by the primary insuring entity must cooperate and assist the primary insuring entity in the reporting process.

(3) If a primary insuring entity and one or more excess insuring entities combine to pay a claim:

- (a) The primary insuring entity must report all paid indemnity and defense and cost

containment expenses; and

(b) The excess insuring entity must cooperate and assist the primary insuring entity in the reporting process.

B. If an excess insuring entity insures a self-insurer and makes indemnity payments or incurs defense and cost containment expenses, the excess insuring entity is principally responsible to report the required closed claim data.

(1) Self-insurers must report all claim payments and defense and cost containment expenses to the excess insuring entity for reporting purposes; and

(2) The excess insuring entity must report data on behalf of itself and the self-insurer.

(3) An excess insuring entity is not responsible to report closed claim data reported by a primary insuring entity under subsection 6A of this Guideline.

C. If a closed claim payment falls within its self-insured retention, the self-insurer must report the required closed claim data.

D. A self-insurer may designate itself to be the principal reporting entity and report closed claim data on behalf of itself and any excess insuring entity. If the self-insurer designates itself to be the principal reporting entity, the self-insurer must:

(1) Notify the commissioner in writing of this arrangement;

(2) Report the required closed claim data on behalf of itself and the excess insuring entity; and

(3) Accept responsibility for compliance with the requirements of subsection 4A of the *Medical Professional Liability Closed Claim Reporting Model Law*.

E. A facility or provider is responsible to report the required closed claim data if:

(1) There is no insurance coverage available from an insuring entity or self-insurer to defend or pay the claim; or

(2) A court of competent jurisdiction determines that the self-insurer, risk retention group or unauthorized insurer is exempt from the *Medical Professional Liability Closed Claim Reporting Model Law*; or

(3) The commissioner grants a waiver under subsection 4A(4)(b) of the *Medical Professional Liability Closed Claim Reporting Model Law*.

Section 7. Reporting of Specific Data Elements

A. Medical specialty—When reporting medical specialties, reporting entities must use the *Specialty Codes* published by the National Practitioner Data Bank. The commissioner may expand the list of medical specialties to include other types of medical providers, such as:

(1) Chiropractor;

(2) Nurse;

(3) Physical therapist;

(4) Physician's assistant; or

(5) Other types of medical providers who commonly provide medical services.

B. Type of health care facility—When reporting the type of health care facility, the reporting entity must use the *Type of Organization Codes* published by the National Practitioner Data Bank (NPDB). Public facilities, such as prisons and universities, must review the NPDB *Type of Organization Codes* and enter the most similar classification.

C. Primary location within a facility—When reporting the primary location within a facility where the incident occurred, the reporting entity must use the incident locations published by the Physician Insurers Association of America in conjunction with its data-sharing project. The reporting entity must report one of these locations:

(1) Catheterization lab;

(2) Critical care unit;

(3) Dispensary;

(4) Emergency department;

(5) Labor and delivery room;

(6) Laboratory;

(7) Nursery;

(8) Operating room;

(9) Outpatient department;

- (10) Patient room;
- (11) Pharmacy;
- (12) Physical therapy department;
- (13) Radiation therapy department;
- (14) Radiology department;
- (15) Recovery room;
- (16) Rehabilitation center;
- (17) Special procedure room;
- (18) Location other than an inpatient facility:
 - (a) Clinical support center, such as a laboratory or radiology center;
 - (b) Office;
 - (c) Walk-in clinic; or
 - (d) Other;
- (19) Other department in hospital;
- (20) Unknown; and
- (21) Other.

D. City—When reporting the city where the incident occurred, the reporting entity must report based on the location of the facility where the incident occurred. If more than one incident led to the claim, the reporting entity must choose the location where the incident leading most directly to the injury occurred.

E. Severity of injury—When reporting the severity of injury, the reporting entity must use the National Practitioner Data Bank severity scale. This scale shows the medical outcome for temporary and permanent injuries.

(1) Temporary injuries include:

- (a) Emotional injury only, such as fright, where no physical damage occurred;
- (b) Insignificant injury, such as lacerations, contusions, minor scars or rash, where no delay in recovery occurs;
- (c) Minor injury, such as infection, fracture set improperly or a fall in the hospital, where recovery is complete but delayed; and
- (d) Major injury, such as burns, surgical material left, drug side effect or brain damage, where recovery is complete but delayed.

(2) Permanent injuries include:

- (a) Minor injury, such as loss of fingers or loss or damage to organs, where the injury is not disabling;
- (b) Significant injury, such as deafness, loss of limb, loss of eye or loss of one kidney or lung;
- (c) Major injury, such as paraplegia, blindness, loss of two limbs or brain damage;
- (d) Grave injury, such as quadriplegia, severe brain damage, life-long care or fatal prognosis; and
- (e) Death.

(3) If several injuries are involved, the reporting entity should report the principal injury.

F. Date of notice—When reporting the date of notice to the insuring entity, self-insurer, facility or provider, the reporting entity must report the date on which:

- (1) The insured notifies the primary insuring entity or self-insurer of a claim if insurance coverage is available; or
- (2) The claimant notifies the facility or provider of a claim if insurance coverage is not available.

G. Claim disposition—When reporting the method of claim disposition, the reporting entity must describe the method of claim disposition using one of the following descriptions:

- (1) Claim is abandoned by the claimant.
- (2) Claim is settled by the parties.
- (3) Claim is disposed of by a court when the court issues a:
 - (a) Directed verdict for the plaintiff;
 - (b) Directed verdict for the defendant;
 - (c) Judgment notwithstanding verdict for the plaintiff (judgment for the defendant);
 - (d) Judgment notwithstanding verdict for the defendant (judgment for the plaintiff);

- (e) Involuntary dismissal;
 - (f) Judgment for the plaintiff;
 - (g) Judgment for the defendant;
 - (h) Judgment for the plaintiff after appeal; or
 - (i) Judgment for the defendant after appeal.
- (4) Claim is settled by an alternative dispute resolution process, whether resolved by:
- (a) Arbitration;
 - (b) Mediation;
 - (c) Private judging or private trial; or
 - (d) Other type of alternative dispute resolution process.
- H. Timing of disposition—When reporting the timing of the claim disposition, the reporting entity must report whether the claim is settled:
- (1) Before filing suit or requesting arbitration or a mediation hearing;
 - (2) Before trial, arbitration or mediation;
 - (3) During trial, arbitration or mediation;
 - (4) After trial or hearing, but before judgment or award;
 - (5) After judgment or decision, but before appeal;
 - (6) During an appeal;
 - (7) After an appeal; or
 - (8) During review panel or non-binding arbitration.
- I. Indemnity payments and defense and cost containment expenses
- (1) When reporting indemnity payments, the reporting entity must report payments on a gross basis and provide the total amount paid to the claimant to settle the claim. The reporting entity must not deduct the value of offsets or recoverables, such as:
 - (a) Reimbursement by the insured for a deductible;
 - (b) Reimbursement by a reinsurer for claim payments; or
 - (c) Anticipated subrogation recoveries.
 - (2) When damages exceed the facility's or provider's policy limits, the reporting entity must report the total amount paid on behalf of the insured, including:
 - (a) The amount paid by the insuring entity. The actual amount paid may be higher or lower than the policy limit, depending on the settlement agreement.
 - (b) Additional payments made by the insured facility or provider to the claimant.
 - (3) Subrogation between insuring entities or self-insurers may occur if there is a dispute over which entity should respond to a lawsuit. If an insuring entity or self-insurer receives a subrogation payment, it must report subrogation proceeds and any defense and cost containment expenses paid to obtain those proceeds. If necessary, the reporting entity may reopen the claim to report this information.
 - (4) Structured settlements
 - (a) If a claim is paid with a structured settlement agreement, the reporting entity must report the lump-sum payment for the purchase of the annuity.
 - (b) If a claim is paid with a combination of a lump-sum payment to the claimant and a structured settlement, the reporting entity must report the sum of both payments.
 - (5) If more than one claim is filed with a reporting entity due to an incident of medical malpractice, the reporting entity must report companion claim payments in this manner:
 - (a) Indemnity payments and defense and cost containment expenses paid to defend and settle each claim must be reported separately for each facility or provider. The reporting entity must allocate indemnity payments between defendants based on an assessment of comparative fault. The reporting entity must allocate defense and cost containment expense payments based on the extent to which each defendant benefited from the defense services.
 - (b) If the reporting entity makes payments in the absence of clear legal liability, it may allocate indemnity payments and defense and cost containment expenses equally among all defendants.
 - (c) The reporting entity is responsible for reporting incident-level data only for its own claims.

(6) When reporting defense and cost containment expenses, the reporting entity must report:

- (a) Defense and cost containment expenses paid for defense counsel, including both in-house and outside counsel;
- (b) Defense and cost containment expenses paid for expert witnesses, including both in-house and outside experts;
- (c) All other defense and cost containment expenses; and
- (d) Total defense and cost containment expenses.

(7) When an insuring entity or self-insurer uses company employees, including professional medical staff and in-house legal counsel, to defend claims, the reporting entity:

- (a) Must include in defense and cost containment expenses the salary, benefits and an allocation of overhead for those employees; and
- (b) May use average salaries and the results of time studies when calculating these defense and cost containment expenses.

J. Estimation of economic and noneconomic damages

(1) If a reporting entity makes indemnity payments to a claimant, the reporting entity must report economic damages based on documented evidence obtained during the claim resolution process. Reporting entities may not determine economic damages using a fixed formula, such as fifty percent of total paid indemnity.

(2) When a reporting entity makes a best estimate of economic damages, the reporting entity must use reasonable judgment to estimate the following elements of loss:

- (a) Medical expenses;
- (b) Loss of earnings;
- (c) Burial costs;
- (d) Loss of use of property;

- (e) Cost of replacement or repair;
- (f) Cost of obtaining substitute domestic service; and
- (g) Loss of business or employment opportunities.

(3) If a reporting entity makes indemnity payments to a claimant that include compensation for future economic damages, the reporting entity must estimate these future economic damages in the following manner:

- (a) Project the elements of loss listed in subsection H(2) of this section for the duration of the injury or disability or, in the event of death, for the anticipated life span of the injured person;
- (b) Discount damages to present value using reasonable discount factors; and
- (c) Consider related factors, such as issues of negligence and liability, the relative strength of the defense, and the component of the indemnity payment driven by economic damages.

(4) The total indemnity payment must be equal to the sum of the reporting entity's best estimate of economic damages and the reporting entity's best estimate of noneconomic damages, and neither estimate may exceed the total indemnity payment.

Section 8. Mechanism for Reporting and Collection of Data

A. The commissioner will establish a web-based reporting site to be used by reporting entities to report the required closed claim data.

B. The state's reporting site should include controls that prevent the entry of illogical or selfcontradictory data.

C. To promote efficiency of reporting and quality of data, the commissioner will, to the extent that it is feasible, make the operation and format of the state's reporting site consistent with the sites of other states.

Section 9. Data Analysis and Annual Reporting by the Commissioner

The commissioner has a responsibility to ensure that the data collected are complete and accurate, to analyze the data using sound statistical methods, and to provide summary reports and data analyses for the legislature and the public.

- A. Before data are summarized and analyzed, the commissioner will check the reasonableness of the data collected and work with reporting entities to ensure that any needed corrections are made.
- B. By June 30 of each year, the commissioner will:
 - (1) Summarize and analyze the data submitted on claims closed in preceding years, using sound statistical methods; and
 - (2) Issue a report including the data, the analysis, and any conclusions that are drawn. This report will be made available to the public on the commissioner's website.
- C. To the extent that data are confidential, the commissioner will protect the data in a manner consistent with provisions used in the state's adoption of Section 6 of the *Medical Professional Liability Closed Claim Reporting Model Law*.

Appendix A provides advice on Data Verification which is an essential part of data analysis and reporting. [Appendix A would be section I of the Guide and Codebook dated July 17, 2008.]

Section 10. Further Distribution of Data

If applicable, the commissioner will make data available to other parties in a manner consistent with provisions used in the state's adoption of Section 6 of the *Medical Professional Liability Closed Claim Reporting Model Law*.

Appendix B examines confidentiality in detail. The appendix section provides two options designed to produce data that are analytically useful while at the same time minimizing the probability that sensitive information will be disclosed [Appendix B would be section II of the Guide and Codebook dated July 17, 2008.]